

Depending on your computer, you may be able to fill out this form on your computer and then email or fax it to us. Try putting your cursor in the fields below.



COLON HEALTH CENTER OF DELAWARE

Please complete this form and email it to schedule@colonhealthcenters.com. Or you can print it and fax it to 302-225-8063. If you set up an appointment with us already, please complete the form, print it out, and bring it with you to your appointment.

Virtual Colonoscopy Registration/Request Form

Name: _____ Requested Day(s)/Date(s) of Study: _____

Home Address: _____

City _____ State _____ Zip _____ SSN: _____ - _____ - _____

Email Address: _____ Do you check email?: Yes No

Home Phone: _____ Cell Phone: _____

Age: _____ DOB: _____ Sex: Male Female Marital Status: Married Single Weight: _____ lbs.

Emergency Contact Person: _____ Relation: _____ Contact #: _____

Primary Physican: _____ GI Physician, if any: _____

Primary Insurance: _____ Secondary Insurance: _____

Member # _____ Member # _____

Group # _____ Group # _____

Subscriber Name (if not you): _____ DOB: _____ SSN: _____

Do you have any personal history of:
Yes No

Colon Cancer or Polyps _____
Prior Colon Cancer Screening _____
Iodine Allergy _____

If yes, which and when: _____
If yes, type of screening and when: _____
If so, type of reaction: _____

Do you currently have any of the following symptoms?
Yes No

Abdominal pain _____
Diarrhea _____
Blood in Stools _____
Constipation _____
Weight Loss _____

Do you take any of the following medications?
Yes No

Aspirin _____
Coumadin/Warfarin _____
Plavix _____
Iron-containing vitamins _____
Fiber Supplements _____

Do you have any of the following conditions?
Yes No

Kidney Failure on Hemodialysis _____
Any Bleeding Disorder _____
Latex Allergy _____
On a Transplant List _____
On Home Oxygen _____
Implanted Cardiac Defibrillator _____
Cardiac Pacemaker _____
Asthma, Emphysema, COPD _____
Congestive Heart Failure _____
Diabetes _____
Diverticulitis _____

If yes, Type of Disorder: _____
If yes, Type of Reaction: _____
If yes, Organ: _____

Patient Signature: _____ Date: _____

Please bring completed form with you when you pick up prep kit, or Fax to 302-225-8063